

COLORADO 2017 EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	State Employee Plan
Issuer Name	Kaiser Foundation Health Plan of Colorado
Product Name	State Employee Health Plan
Plan Name	Colorado State LG A230 State Employee Health Plan
Supplemented Categories (Supplementary Plan Type)	Pediatric dental (CHIP)

BENEFITS AND LIMITS

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				
Specialist Visit	Yes	Covered	No				
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				
Hospice Services	Yes	Covered	No			If you elect to receive hospice care, you will not receive additional benefits for the terminal illness.	If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.
Routine Dental Services (Adult)	No	Not Covered	No				
Infertility Treatment	Yes	Covered	No			a. Services to reverse voluntary, surgically induced infertility. b. All Services and supplies (other than artificial insemination) related to conception by artificial means. This means prescription drugs related to such Services, and donor semen and donor eggs used for such Services, such as, but not limited to in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer are not covered. These exclusions apply to fertile as well as infertile individuals or couples.	We cover the following Services, including X-ray and laboratory procedures: (a) Services for diagnosis and treatment of involuntary infertility; and (b) artificial insemination, except for donor semen, donor eggs and Services related to their procurement and storage.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				
Private-Duty Nursing	Yes	Covered	No				For hospital inpatient care, private duty nursing covered when a Plan Physician determines it is Medically Necessary.
Routine Eye Exam (Adult)	No	Covered	No			a. Eyeglass lenses and frames. b. Contact lenses. c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary. d. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy and similar procedures). e. Orthoptic (eye training) therapy.	We cover wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses. We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition. Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.
Urgent Care Centers or Facilities	Yes	Covered	No				

A Benefit	B EHB	C Is the Benefit Covered?	D Quantitative Limit on Service?	E Limit Quantity	F Limit Unit	G Exclusions	H Explanations
Home Health Care Services	Yes	Covered	Yes	28	Hours per Week	a. Custodial care. b. Homemaker Services. c. Care that Medical Group determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.	We cover skilled nursing care, home health aide Services and medical social Services: a. only on a Part-Time Care or Intermittent Care basis; and b. only within our Service Area; and c. only if you are confined to your home; and d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Health Plan may approve additional time up to 35 hours per week but less than eight (8) hours per day on a case-by-case basis.
Emergency Room Services	Yes	Covered	No				
Emergency Transportation/Ambulance	Yes	Covered	No			Transportation by other than a licensed ambulance.	
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No			(A)Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by State Law, (B) Cosmetic surgery related to bariatric surgery.	
Inpatient Physician and Surgical Services	Yes	Covered	No				
Bariatric Surgery	Yes	Covered	No				You must meet Medical Group's criteria to be eligible for coverage.
Cosmetic Surgery	No	Not Covered	No				
Skilled Nursing Facility	Yes	Covered	Yes	100	Days Per Year	Custodial Care.	We cover the following Services: a. Room and board. b. Nursing care. c. Medical social Services. d. Medical and biological supplies. e. Blood, blood products and their administration.
Prenatal and Postnatal Care	Yes	Covered	No				
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				
Mental/Behavioral Health Outpatient Services	Yes	Covered	No			a. Evaluations for purposes other than mental health treatment; b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder; c. Mental health services ordered by a court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary; d. Court-ordered testing and testing for ability, aptitude, intelligence or interest; e. Services which are custodial or residential in nature.	We cover diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling. Visits for the purpose of monitoring drug therapy are covered. Psychological testing as part of diagnostic evaluation is covered.

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Mental/Behavioral Health Inpatient Services	Yes	Covered	No			a. Evaluations for purposes other than mental health treatment; b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether associated with manifest mental disorder; c. Mental health services ordered by a course, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary; d. Court-ordered testing and testing for ability, aptitude, intelligence or interest; e. Services which are custodial or residential in nature.	We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.
Substance Abuse Disorder Outpatient Services	Yes	Covered	No			We do not cover court-ordered treatment that exceeds the scope of this health benefit plan.	Outpatient rehabilitative Services for the treatment of alcohol and drug dependency are covered when referred by a Plan Physician.
Substance Abuse Disorder Inpatient Services	Yes	Covered	No			We do not cover court-ordered treatment that exceeds the scope of this health benefit plan.	We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.
Generic Drugs	Yes	Covered	No				
Preferred Brand Drugs	Yes	Covered	No				
Non-Preferred Brand Drugs	Yes	Covered	No				
Specialty Drugs	Yes	Covered	No				
Outpatient Rehabilitation Services	Yes	Covered	Yes	20	Visit(s) per Year	a. Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature. b. Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living. a. Long-term rehabilitation, not including treatment for autism spectrum disorders. b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.	Limit is per therapy.

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Habilitation Services	Yes	Covered	Yes	60	Visit(s) per Year	a. Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature. b. Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living. a. Long-term rehabilitation, not including treatment for autism spectrum disorders. b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.	20 visit limit per therapy.
Chiropractic Care	Yes	Covered	Yes	20	Visit(s) per Year	a. Hypnotherapy. b. Behavior training. c. Sleep therapy. d. Weight loss programs. e. Services not related to the treatment of the musculoskeletal system. f. Vocational rehabilitation Services. g. Thermography. h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances. i. Transportation costs. This includes local ambulance charges. j. Prescription drugs, vitamins, minerals, food supplements or other similar products. k. Educational programs. l. Non-medical self-care or self-help training. m. All diagnostic testing related to these excluded Services. n. MRI and/or other types of diagnostic radiology. o. Physical or massage therapy that is not a part of the chiropractic treatment. p. Durable medical equipment (DME) and/or supplies for use in the home.	Coverage includes: a. Evaluation; b. Lab Services and X-rays required for chiropractic Services; and c. Treatment of musculoskeletal disorders.

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Durable Medical Equipment	Yes	Covered	No			Coverage is limited to a standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs, Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan. i. Electronic monitors of bodily functions, except infant apnea monitors are covered. ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered. iii. Non-medical items such as sauna baths or elevators. iv. Exercise or hygiene equipment. v. Comfort, convenience, or luxury equipment or features. vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans. vii. Replacement of lost equipment. viii. Repairs, adjustments or replacements necessitated by misuse. ix. More than one piece of DME serving essentially the same function, except for replacements. x. Spare equipment or alternate use equipment is not covered.	When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided as shown on the "Summary Chart" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge. You will be charged as a non-Member for items of DME, prosthetics and orthotics until your Deductible is met, if applicable.
Hearing Aids	Yes	Covered	No				Persons Under the Age of 18 Years: The plan covers: a. Initial hearing aids and replacement hearing aids not more frequently than every 5 years; b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				
Preventive Care/Screening/Immunization	Yes	Covered	No				
Routine Foot Care	No	Not Covered	No				Routine foot care Services that are not Medically Necessary.
Acupuncture	No	Not Covered	No				
Weight Loss Programs	No	Not Covered	No				
Routine Eye Exam for Children	Yes	Covered	No				The plan covers wellness and refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses.
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per 2 Years	Exclusion: Replacement of lost or broken lenses or frames.	1 pair every 24 months includes the frames and lenses or contact lenses.
Dental Check-Up for Children	Yes	Covered	No				

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Rehabilitative Speech Therapy	Yes	Covered	Yes	20	Visit(s) per Year	Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems. Long-term rehabilitation, not including treatment for autism spectrum disorders.	Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature. Covered if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period.
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	20	Visit(s) per Year	Long-term rehabilitation, not including treatment for autism spectrum disorders.	Covered if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period. 60-day limit for inpatient rehab.
Well Baby Visits and Care	Yes	Covered	No				
Laboratory Outpatient and Professional Services	Yes	Covered	No				
X-rays and Diagnostic Imaging	Yes	Covered	No				
Basic Dental Care - Child	Yes	Covered	No				Diagnostic and Preventive Limitations 1. Prophylaxis (cleaning) is a benefit only ONCE in a 12 month period. 2. Oral evaluations (exams) are a benefit twice in a 12 month period. 3. Topical fluoride application is a benefit twice in a 12 month period. 4. Bitewing x-rays are a benefit only ONCE in a 12 month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months. 5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth. 6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations. 7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application. 8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
Orthodontia - Child	No	Not Covered	No				

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Major Dental Care - Child	Yes	Covered	No				Diagnostic and Preventive Limitations 1. Prophylaxis (cleaning) is a benefit only ONCE in a 12 month period. 2. Oral evaluations (exams) are a benefit twice in a 12 month period. 3. Topical fluoride application is a benefit twice in a 12 month period. 4. Bitewing x-rays are a benefit only ONCE in a 12 month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months. 5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth. 6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations. 7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application. 8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
Basic Dental Care - Adult	No	Not Covered	No				
Orthodontia - Adult	No	Not Covered	No				
Major Dental Care – Adult	No	Not Covered	No				
Abortion for Which Public Funding is Prohibited	No	Covered	No			Voluntary, elective abortions and any related Services, drugs or supplies are excluded. Exceptions to this are: 1. When an abortion is Medically Necessary to preserve the life or health of the mother if the pregnancy continues to term; or 2. When the pregnancy is the result of an act of rape or incest; or 3. Treatment of complications following an abortion.	

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Transplant	Yes	Covered	No			a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded. b. Non-human and artificial organs and their implantation are excluded. c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria. d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the Transplant Administrative Offices.	Transplants are covered on a LIMITED basis as follows: a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants. b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome. c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue or bone marrow.
Accidental Dental	No	Not Covered	No				
Dialysis	Yes	Covered	No				We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met: 1. The Services are provided inside our Service Area; and 2. You meet all medical criteria developed by Medical Group and by the facility providing the dialysis; and 3. The facility is certified by Medicare and contracts with Medical Group; and 4. A Plan Physician provides a written referral for care at the facility.
Allergy Testing	Yes	Covered	No				
Chemotherapy	Yes	Covered	No				"Orally administered anti-cancer medication" covered even under basic drug option.
Radiation	Yes	Covered	No				Radioactive materials used for therapeutic purposes.
Diabetes Education	Yes	Covered	No				

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Prosthetic Devices	Yes	Covered	No			Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.	We cover the following prosthetic devices, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan: i. Internally implanted devices for functional purposes, such as pacemakers and hip joints. ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prostheses is no longer functional. Custom-made prostheses will be provided when necessary. iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn Members when prescribed by a Plan Physician and obtained from sources designated by Health Plan. iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accord with this EOC. Including repairs and replacements, of such prosthetic devices.
Infusion Therapy	Yes	Covered	No				
Treatment for Temporomandibular Joint Disorders	Yes	Covered	No				TMJ listed in exclusions but "The following Services for TMJ may be covered if a Plan Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery."
Nutritional Counseling	Yes	Covered	No				
Reconstructive Surgery	Yes	Covered	No			Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.	We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma (port wine stains) on the face and neck of Members 18 years and younger. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

PREScription DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS

CATEGORY	CLASS	SUBMISSION COUNT
Analgesics	Nonsteroidal Anti-inflammatory Drugs	8
Analgesics	Opioid Analgesics, Long-acting	3
Analgesics	Opioid Analgesics, Short-acting	7
Anesthetics	Local Anesthetics	2
Anti-Addiction/ Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	2
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Dependence Treatments	1
Anti-Addiction/ Substance Abuse Treatment Agents	Opioid Reversal Agents	1
Anti-Addiction/ Substance Abuse Treatment Agents	Smoking Cessation Agents	0
Antibacterials	Aminoglycosides	4
Antibacterials	Antibacterials, Other	11
Antibacterials	Beta-lactam, Cephalosporins	4
Antibacterials	Beta-lactam, Other	2
Antibacterials	Beta-lactam, Penicillins	5
Antibacterials	Macrolides	3
Antibacterials	Quinolones	5
Antibacterials	Sulfonamides	3
Antibacterials	Tetracyclines	3
Anticonvulsants	Anticonvulsants, Other	3
Anticonvulsants	Calcium Channel Modifying Agents	3
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Augmenting Agents	2
Anticonvulsants	Glutamate Reducing Agents	3
Anticonvulsants	Sodium Channel Agents	4
Antidementia Agents	Antidementia Agents, Other	1
Antidementia Agents	Cholinesterase Inhibitors	2
Antidementia Agents	N-methyl-D-aspartate (NMDA) Receptor Antagonist	1
Antidepressants	Antidepressants, Other	5
Antidepressants	Monoamine Oxidase Inhibitors	2
Antidepressants	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	6
Antidepressants	Tricyclics	6
Antiemetics	Antiemetics, Other	8
Antiemetics	Emetogenic Therapy Adjuncts	3
Antifungals	No USP Class	9
Antigout Agents	No USP Class	4
Anti-inflammatory Agents	Glucocorticoids	18
Anti-inflammatory Agents	Nonsteroidal Anti-inflammatory Drugs	7
Antimigraine Agents	Ergot Alkaloids	2

CATEGORY	CLASS	SUBMISSION COUNT
Antimigraine Agents	Prophylactic	2
Antimigraine Agents	Serotonin (5-HT) 1b/1d Receptor Agonists	3
Antimyasthenic Agents	Parasympathomimetics	2
Antimycobacterials	Antimycobacterials, Other	1
Antimycobacterials	Antituberculars	4
Antineoplastics	Alkylating Agents	4
Antineoplastics	Antiandrogens	3
Antineoplastics	Antiangiogenic Agents	2
Antineoplastics	Antiestrogens/Modifiers	2
Antineoplastics	Antimetabolites	4
Antineoplastics	Antineoplastics, Other	4
Antineoplastics	Aromatase Inhibitors, 3rd Generation	3
Antineoplastics	Enzyme Inhibitors	1
Antineoplastics	Molecular Target Inhibitors	8
Antineoplastics	Monoclonal Antibodies	0
Antineoplastics	Retinoids	1
Antiparasitics	Anthelmintics	3
Antiparasitics	Antiprotozoals	8
Antiparasitics	Pediculicides/Scabicides	1
Antiparkinson Agents	Anticholinergics	3
Antiparkinson Agents	Antiparkinson Agents, Other	2
Antiparkinson Agents	Dopamine Agonists	3
Antiparkinson Agents	Dopamine Precursors/ L-Amino Acid Decarboxylase Inhibitors	1
Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	1
Antipsychotics	1st Generation/Typical	10
Antipsychotics	2nd Generation/Atypical	5
Antipsychotics	Treatment-Resistant	1
Antispasticity Agents	No USP Class	2
Antivirals	Anti-cytomegalovirus (CMV) Agents	1
Antivirals	Anti-hepatitis B (HBV) Agents	5
Antivirals	Anti-hepatitis C (HCV) Agents	5
Antivirals	Antitherpetic Agents	3
Antivirals	Anti-HIV Agents, Integrase Inhibitors (INSTI)	2
Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)	5
Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	12
Antivirals	Anti-HIV Agents, Other	2
Antivirals	Anti-HIV Agents, Protease Inhibitors	9
Antivirals	Anti-influenza Agents	3

CATEGORY	CLASS	SUBMISSION COUNT
Anxiolytics	Anxiolytics, Other	3
Anxiolytics	Benzodiazepines	0
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	3
Bipolar Agents	Bipolar Agents, Other	6
Bipolar Agents	Mood Stabilizers	5
Blood Glucose Regulators	Antidiabetic Agents	5
Blood Glucose Regulators	Glycemic Agents	1
Blood Glucose Regulators	Insulins	5
Blood Products/Modifiers/ Volume Expanders	Anticoagulants	5
Blood Products/Modifiers/ Volume Expanders	Blood Formation Modifiers	3
Blood Products/Modifiers/ Volume Expanders	Coagulants	0
Blood Products/Modifiers/ Volume Expanders	Platelet Modifying Agents	6
Cardiovascular Agents	Alpha-adrenergic Agonists	2
Cardiovascular Agents	Alpha-adrenergic Blocking Agents	4
Cardiovascular Agents	Angiotensin II Receptor Antagonists	1
Cardiovascular Agents	Angiotensin-converting Enzyme (ACE) Inhibitors	2
Cardiovascular Agents	Antiarrhythmics	8
Cardiovascular Agents	Beta-adrenergic Blocking Agents	6
Cardiovascular Agents	Calcium Channel Blocking Agents	5
Cardiovascular Agents	Cardiovascular Agents, Other	2
Cardiovascular Agents	Diuretics, Carbonic Anhydrase Inhibitors	2
Cardiovascular Agents	Diuretics, Loop	3
Cardiovascular Agents	Diuretics, Potassium-sparing	3
Cardiovascular Agents	Diuretics, Thiazide	4
Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2
Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	4
Cardiovascular Agents	Dyslipidemics, Other	2
Cardiovascular Agents	Vasodilators, Direct-acting Arterial	2
Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	3
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	1
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	2
Central Nervous System Agents	Central Nervous System, Other	2
Central Nervous System Agents	Fibromyalgia Agents	1
Central Nervous System Agents	Multiple Sclerosis Agents	3
Dental and Oral Agents	No USP Class	5
Dermatological Agents	No USP Class	45
Enzyme Replacement/ Modifiers	No USP Class	1
Gastrointestinal Agents	Antispasmodics, Gastrointestinal	2

CATEGORY	CLASS	SUBMISSION COUNT
Gastrointestinal Agents	Gastrointestinal Agents, Other	6
Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	3
Gastrointestinal Agents	Irritable Bowel Syndrome Agents	1
Gastrointestinal Agents	Laxatives	1
Gastrointestinal Agents	Protectants	2
Gastrointestinal Agents	Proton Pump Inhibitors	2
Genitourinary Agents	Antispasmodics, Urinary	1
Genitourinary Agents	Benign Prostatic Hypertrophy Agents	5
Genitourinary Agents	Genitourinary Agents, Other	3
Genitourinary Agents	Phosphate Binders	2
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)	No USP Class	22
Hormonal Agents, Stimulant/ Replacement/ Modifying (Prostaglandins)	No USP Class	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Anabolic Steroids	1
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Androgens	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progesterone Agonists/Antagonists	0
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	3
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Selective Estrogen Receptor Modifying Agents	1
Hormonal Agents, Stimulant/Replacement/ Modifying (Pituitary)	No USP Class	3
Hormonal Agents, Stimulant/Replacement/ Modifying (Thyroid)	No USP Class	2
Hormonal Agents, Suppressant (Adrenal)	No USP Class	1
Hormonal Agents, Suppressant (Parathyroid)	No USP Class	2
Hormonal Agents, Suppressant (Pituitary)	No USP Class	5
Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	3
Immunological Agents	Angioedema (HAE) Agents	1
Immunological Agents	Immune Suppressants	13
Immunological Agents	Immunizing Agents, Passive	0
Immunological Agents	Immunomodulators	9
Inflammatory Bowel Disease Agents	Aminosaliclates	2
Inflammatory Bowel Disease Agents	Glucocorticoids	5
Inflammatory Bowel Disease Agents	Sulfonamides	1
Metabolic Bone Disease Agents	No USP Class	5
Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Analogs	1
Ophthalmic Agents	Ophthalmic Agents, Other	11
Ophthalmic Agents	Ophthalmic Anti-allergy Agents	1
Ophthalmic Agents	Ophthalmic Antiglaucoma Agents	10
Ophthalmic Agents	Ophthalmic Anti-inflammatories	6
Otic Agents	No USP Class	6

CATEGORY	CLASS	SUBMISSION COUNT
Respiratory Tract/ Pulmonary Agents	Antihistamines	5
Respiratory Tract/ Pulmonary Agents	Anti-inflammatories, Inhaled Corticosteroids	5
Respiratory Tract/ Pulmonary Agents	Antileukotrienes	1
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Anticholinergic	2
Respiratory Tract/ Pulmonary Agents	Bronchodilators, Sympathomimetic	7
Respiratory Tract/ Pulmonary Agents	Cystic Fibrosis Agents	2
Respiratory Tract/ Pulmonary Agents	Mast Cell Stabilizers	1
Respiratory Tract/ Pulmonary Agents	Phosphodiesterase Inhibitors, Airways Disease	3
Respiratory Tract/ Pulmonary Agents	Pulmonary Antihypertensives	5
Respiratory Tract/ Pulmonary Agents	Respiratory Tract Agents, Other	1
Skeletal Muscle Relaxants	No USP Class	2
Sleep Disorder Agents	GABA Receptor Modulators	1
Sleep Disorder Agents	Sleep Disorders, Other	1
Therapeutic Nutrients/ Minerals/ Electrolytes	Electrolyte/Mineral Modifiers	4
Therapeutic Nutrients/ Minerals/ Electrolytes	Electrolyte/Mineral Replacement	3
Therapeutic Nutrients/ Minerals/ Electrolytes	Vitamins	0